MENTAL HEALTH AMBULANCE TRANSPORT INTAKE FORM

Patient Name: _____ DOB: _____

Medical Record #: _____ Attending Physician: _____

Destination Facility and Department/Floor: _____

Date and Time Requested For Transport: _____

Could this patient be transported by non-secure means (private vehicle, public transportation, other) YES NO

Patient's medical condition that requires transport by ambulance: _____

_____

If after 5:00 pm, could transport be scheduled during daytime business hours? YES NO

If no, explain: _____

Is this patient being transported involuntarily for an inpatient emergency examination (EE)? YES NO

Has the patient been screened by a United Counseling Service (UCS) Emergency Services staff member?

YES NO If yes, provide name (if known): _____

Is patient considered to be a danger to: Self? YES NO Public? YES NO (specify which one or both)

Is patient in restraints? YES NO Will restraints be necessary during transport? YES NO

Is patient sedated? YES NO Will sedation be required during transport? YES NO

Will hospital staff or other mental health personnel be on board? YES NO If yes, provide name(s), title(s), and department(s)/floor(s): _____

Will law enforcement be on board? YES NO
If yes, agency name, contact person, and phone #: _____

Has destination facility approved admission? YES NO
If yes, name and phone # of authorizing person: _____

Has destination facility approved evaluation only? YES NO N/A
If yes, name and phone # of authorizing person: _____

Does the patient have insurance to cover this transport? YES NO
If no, method of payment: __ Self-Pay __ Personal Check __ Credit Card __ Other (describe below)

_____

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For ambulance service use only:

Date & Time Request Received: _____ Received By: _____